INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION

"People helping people help themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Office of Medicaid Policy and Planning
MS 07, 402 W. WASHINGTON STREET, ROOM W382
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October 31, 2006

Judy Norris
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management
Mail Stop C2-21-15
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Norris

The State of Indiana's Family and Social Services Administration (FSSA), Office of Medicaid Policy and Planning, is pleased to submit the attached proposal responding to the Money Follows the Person Rebalancing Demonstration. This proposal is titled, "Indiana Nursing Facility Transition Project." The principal contact person for this grant is Cynthia Brown she can be reached at (317)232-7900 or Cynthia.brown@fssa.in.gov. Indiana is requesting $21,593,916 to participate in the full five year period of this demonstration.

The Office of Medicaid Policy and Planning (OMPP) is the State Medicaid Agency. OMPP is housed under the umbrella of Family and Social Services Administration. We will work hand in hand with the Division of Aging and the Division of Disability and Rehabilitative Services, both divisions within FSSA, to reach three populations with this demonstration. We will target the elderly, individuals with a physical disability including those with traumatic brain injury, and individuals with a developmental disability through this demonstration. Project management will be overseen by the Division of Aging.

As is evidenced by this proposal, FSSA has been and will continue to partner with other government agencies, community partners, the aging community, the DD community and their advocates to provide guidance in the implementation of this effort if funds are received. Major partners who will collaborate in the grant include, The Area Agencies on Aging, AARP-Indiana, the Indiana Health Care Association, The Indiana Association of Home and Services for the Aging, Indiana Housing and Community Development Authority, Aging and Disability Consumers, The ARC of Indiana, INARF, and the Brain Injury Association of Indiana.

Thank you for your consideration of this proposal. The State of Indiana looks forward to the opportunity to continue to improve our long term care system.

Sincerely,

Jeanne M. LaBrecque
Director of Health Policy and Medicaid

Attachment

Project Abstract and Profile

Goals

Indiana proposes to strengthen and expand institutional transition activities through access to the Money Follows the Person demonstration grant. Indiana is engaged in a number of initiatives designed to increase access to HCBS, including a NF closure and conversion program, a NF diversion program, closure of the State developmental centers and transition of self-referred NF residents. Indiana's goals specific to the demonstration include: proactively identify NF residents (elders, adults with physical disabilities, including TBI, and adults with MR/DD) who have been institutionalized for at least six months who have expressed a desire to move to small community-based settings;, provide comprehensive options counseling to these residents, facilitating informed choice regarding their options for alternative LTC; facilitate and ensure safe transition to a qualified community setting; ensure access to these settings, including adult foster care homes, residential habilitation homes, family or independent homes and access to other necessary supports and services; ensure follow up throughout the first year of adjustment to the new setting; track and evaluate outcomes for these individuals; and use this outcome-based data to refine Indiana's ongoing transition efforts. FSSA has set a long-term goal of rebalancing the LTC system through the combined efforts specific to all institutional diversion and transition activities to achieve a more equitable balance between institutional and HCBS options.

Total Budget

Indiana is proposing a budget (Federal share) of: $21,593,916 for the demonstration, comprised of: $18,599,258 for 12 months of qualified HCBS per participant provided between 2007 and 2011, $ 629,981 for demonstration services and $2,364,637 for administration (of which $1,847, 857 is for transition team expenses and $162,847 for staffing of the project including $52535 for the full-time project director.

Grant Fund Use

Funds will be used to support a strengthened stakeholder input process; help develop and improve transition team training materials and processes; develop options counseling materials and processes to increase personal choice; implement an improved assessment process for home care; and develop and implement person centered planning. The integration and coordination of services and supports across programs including HCBS waivers, Medicaid state plan services, OAA services, CHOICE state-funded services, etc. will be improved through improved IT system integration. Funds will also support the work of the full-time project director who will participate in system change activities, emphasizing the specific needs of demonstration participants including the transition process, the development of community capacity, especially small, residential options like apartments and adult foster care settings, accessible transportation, home care and meals and improvement of the quality oversight and improvement processes.

Ultimate Outcomes and Products

Indiana seeks to develop a more mature transition program that formalizes identification of individuals residing in NFs who have expressed a desire to move to community-based settings and, to the extent desired by the individual, facilitates their successful transitions to small, community-based settings. Successful targeting, a reliable assessment tool, and a person-centered planning and follow along process that is clinically guided will guide this process. Indiana anticipates transitioning 1,039 individuals as a result of access to this grant.

Part I: Systems Assessment and Gap Analysis (20 pg limit)

The following analysis is based on an independent statewide needs assessment completed in 2005 as well as input from stakeholders including consumers, case managers, service providers, and advocacy and support organizations. Input was also received from a stakeholders group that convened in February 2006 and was the seed of a larger group now addressing transition issues in general. Both these groups, as well as ongoing interaction with case managers and consumer focus groups concerning our consumer directed care initiative, have been utilized to help identify needs to be addressed for those transitioning. These include methods to identify transition candidates, improved methods for assessment of candidates and identification of community-based needs, access to clinical oversight after transition, access to critical supports like in-home services, nutritious meals, on-demand transportation, and appropriate housing, and methods to improve quality of services and help participants achieve desired outcomes.

1. **A description of the current LTC support systems that provide institutional and home and community based services, including any major legislative initiatives that have affected the system.** Evolving from a series of grassroots and higher-level formal initiatives, Indiana's Family and Social Services Administration's (FSSA) Aging Reform Agenda, developed in 2005 and early 2006, has developed a new strategic direction for a comprehensive, integrated long-term care (LTC) system. Specifically designed to transform the model of long-term care to include an array of home and community-based services (HCBS) with less dependency on institutional care, the Agenda's objectives include strategies to: improve public awareness, increase service capacity, expand access, and rebalance LTC spending away from institutional care and toward HCBS. The vitality of these changes has been energized by a unique and unprecedented period of innovation and systems improvement for LTC that are part of a larger

agency-wide theme focused on the business model of "reinventing healthcare" that is in alignment with the governor's public dedication to performance measurement. Key LTC staff in FSSA DA, joined by skilled consultants, met on a weekly basis for the first half of 2006 to develop the new system of LTC and accompanying policies, waiver amendments, budget issues and other items necessary to effect desired changes. In addition, FSSA staff met with a Capacity Workgroup and a consumer advocate group bi-monthly since February 2006, absorbing and utilizing the knowledge and expertise of a range of stakeholders to build HCB service and provider capacity. In July 2006, the Division of Aging (DA) was created as a separate division from the previous Division of Disability, Aging, and Rehabilitation Services (DDARS). Simultaneously, the complete budgetary responsibility for Nursing Facilities (NF) and NF level of care (LOC) HCBS waivers transitioned to FSSA DA from the Office of Medicaid Policy and Planning (OMPP). FSSA DA subsequently developed the LTC OPTIONS Program, which has been instrumental in increasing knowledge and supply of critical, core LTC services emphasizing home care services (including attendant care and homemaker services), home health services, adult foster care, adult day services, assisted living, and nursing facility services.

Advocates in Indiana have long sought implementation of the higher (300% SSI) income standard for HCBS waivers, in order to ensure equivalent Medicaid eligibility requirements between NF and HCBS waiver programs. This option was implemented effective July 1, 2006. These efforts, along with a substantial increase in HCBS service rates and the addition of a large number of slots for both the Aged and Disabled (AD) Waiver and Developmental Disabilities (DD) Waiver, clearly indicate Indiana's strong commitment to expanding access to HCBS. (Appendix L) Furthermore, the implementation of Indiana's NF Closure and Conversion fund, along with a NF moratorium, is helping to proactively rebalance the LTC system. An AD Waiver

amendment, submitted August 4, 2006 to CMS, included a restatement of priority criteria for direct entrance onto the AD Waiver. These include diversions due to imminent risk of institutionalization following discharge from an inpatient stay at a hospital facility, loss of primary caregiver due to death or incapacitation, receiving State funded HCBS services through CHOICE but eligible for the AD Waiver, and transitioning from a NF.

The MFP demonstration grant opportunity comes at an ideal time for Indiana – the grant will assist the State in continuing LTC reform and in accelerating NF transitions while strengthening the transition process. An outline of the network that exists to support the LTC needs of the four target groups comprising three demonstration populations, included in the MFP demonstration: elders, adults with a physical disability and adults with a traumatic brain injury (TBI), and adults with a developmental disability (DD)follows: **Area Agencies on Aging**: In 1992, Indiana enacted legislation that designated the network of 16 Area Agencies on Aging (AAAs) that serve all 92 counties in Indiana to function as the single point of entry for in-home and community based services for elders and adults with physical disabilities. The AAA's now also provide NF pre-admission screening for all individuals seeking access to NF services irrespective of funding source. They are now the entry point for access to HCBS waiver services for elders and individuals of all ages with physical disabilities and to the nationally recognized, 100% State-funded, Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) program along with services funded by the Older Americans Act (OAA) and Social Service Block Grant (SSBG). Indiana was one of the first states to develop a single point of entry system. The AAAs have an excellent history of community coordination and partnerships with local providers. **Aging and Disability Resource Centers (ARDC)**: Indiana has continued to lead in the development of one-stop resources. In 2004, Indiana was awarded

an Aging and Disability Resource Center (ADRC) Grant from the Administration on Aging (AOA) and Centers for Medicare and Medicaid Services (CMS). Two AAAs were designated as ADRC pilot sites to begin operating "one-stop shopping" resource centers, which have been open since June 30, 2005. The ADRCs will provide extensive information and referral (I & R) services and coordination with other agencies and programs. For example, working with counselors to identify available and appropriate housing resources, DFR eligibility workers to secure or verify Medicaid eligibility, and Social Security counselors to secure or verify receipt of SSI. In addition, the ADRCs provide a variety of training sessions and workshops related to LTC issues, including extensive options counseling.. The existing ADRCs have used their experiences to develop Standard Operating Procedures and Core Competencies for the two additional sites to be established through the grant. This information will be used for future statewide expansion of ADRCs. The first year of the grant was devoted to planning and development and allowed the ADRCs to focus on staff development, local partnerships, pre-evaluation, uniform software (which includes web-based access to resource directories), and to develop a marketing plan to introduce private pay individuals, local businesses and professionals to the ADRC functions. The second year of the grant added "one-stop shopping" services for persons with physical disabilities at the two original sites. The next two sites will be located in Yorktown, IN and Columbus, IN and will be opened in 2006, with implementation statewide by June 2007. During 2005, Indiana received $48,000 in supplemental ADRC funding which enabled the contracted marketing firm to create a video for "Link-Age", Indiana's ADRC website. The video can be viewed on the ADRC-TAE website and "Link-Age" can be accessed at http://www.Link-age.org. Indiana's pilot sites have made progress in streamlining access to Medicaid services by creating a Medicaid Application Packet that can be accessed on the Link-Age website. **Community and**

Home Options to Institutional Care for the Elderly and Disabled (CHOICE): The CHOICE program began in the late 1980s as a state funded program to provide case management services, assessment, and in-home and community services to adults who are at least 60 years of age or persons of any age who have a disability due to a mental or physical impairment, who have no more than $500,000 in assets, and who are found to be at risk of loosing their independence. The CHOICE program, enacted in State statute in 1987, began as a pilot in just three counties and by 1992 was implemented in all 92 Indiana counties. Today, the CHOICE program is a nationally recognized program that operates with 100% state funds. In 2004, 10,488 Hoosiers were served through the CHOICE program. The State spent over $35 million for CHOICE services in 2004.

HCBS Waivers: The OMPP, DA and DDRS work together to operate six HCBS waiver programs serving the state. They provide a wide array of services, which are listed in Appendix J. Recent initiatives to enhance the HCBS waivers include legislatively authorized provider rate increases, waiver expansions, targeted HCBS provider development, and waiver amendments to raise the income limit to 300% of the Supplemental Security Income (SSI) amount (thus equivalent to that for NFs) and increase the amount waiver enrollees may retain to meet community-based expenses. **Quality Assessment Fee (QAF)**: In April 2005, a state plan amendment allowing Indiana to implement a Quality Assessment Fee (QAF) for NFs in the state was approved by CMS, a portion of which may be used to incentivize NF bed closures. **DD-Specific Services**: Indiana offers an array of services for individuals with developmental disabilities (DD). Services are offered in ICFs/MR and a range of community-based settings. The State is in the final stages of closure of the last remaining state developmental center. The Ft. Wayne State Developmental Center is scheduled to close in SFY 2007. This closure is discussed in more detail under item 2. The vast majority of individuals with DD are served

through one of three HCBS waivers: the DD Waiver, the Support Services Waiver or the Autism Waiver. These waivers operate with an annual budget of approximately $379.7 million (State and Federal funds). Please see points 3 & 4 for detailed information regarding these waiver programs in Indiana. **Major Legislative Initiatives:** Several legislative initiatives have impacted the Long-Term Care support system in Indiana. The most recent legislative actions include: ***Senate Enrolled Act No. 432 (Passed in 2005)*** - SEA 432 established a committee to study the effects of a moratorium on the construction of new nursing facilities and hospitals. Among other stipulations, the law mandates the Family and Social Services Administration to develop a long-term care plan that will determine the number of NF beds that the State needs and to recommend alternative payment systems and provider systems for long-term care under the state's Medicaid program. A moratorium was subsequently imposed. (Appendix C) ***Senate Enrolled Act No. 493 (Passed in 2003)*** - SEA 493 required the Family and Social Services Administration to establish a comprehensive program of home and community-based long-term care services that are not more costly than services provided by institutions. The law also required FSSA to examine the effect of changing eligibility criteria to increase the income limit to 300% of SSI for HCBS waivers. This legislation created a legislative mandate to the DA to expand access to the AD Waiver and implement the increased income level for this waiver. (Appendix D) ***House Enrolled Act. No. 1662 (Passed in 2005)*** - HEA 1662 required the collection of quality assessment fees from nursing home facilities that receive reimbursement from Medicaid. By authorizing the collection of the quality assessment fee from nursing facilities, FSSA was able to establish a closure/conversion fund to financially assist with its transition efforts. The fund is now operational. (Appendix E) *Rule 460 IAC 1.2* concerning home and community based services, was promulgated by FSSA during 2006. The rule includes qualifications for approved providers

of home and community based services; the process by which providers are approved; standards and requirements for approved providers of home and community based services; the process for monitoring and ensuring compliance with provider standards and requirements; the rights and protection of individuals receiving services; and definitions for home and community based services funded through BAIHS, including the HCBS waivers. (Appendix F)

2. **An assessment of what is in place and working to rebalance the State's resources, i.e. to increase the use of home and community based rather than institutional, long-term care services.** The FSSA has worked extensively on rebalancing funding between institutional and community-based services for all populations. Efforts have focused on downsizing and closure of state facilities, increases in HCBS waiver services, and NF transition and diversion efforts.

State Developmental Centers: Indiana closed the Muscatatuck State Developmental Center, one of two state developmental centers in Indiana, in June 2005. From the time that the closure of the center was announced in April of 2001, over 279 individuals were transitioned to new homes in a community setting, with only five individuals moved to another institutional setting. One major achievement in that rebalancing effort was the ability for an individual's funding to follow them from the institution to their new community setting. The closure of Fort Wayne Developmental Center (FWSDC) was announced in 2005, and the facility is scheduled to close on July 1, 2007. The census at FWSDC has declined by 660 persons since January 1, 1999. It is anticipated that the vast majority of individuals remaining to be transitioned will be moved to a community setting, with only a handful being placed in another institutional setting. In the last twelve years, the population of large congregate facilities has been reduced by over 2,300 individuals. **Increases in HCBS Waiver Services**: Indiana has grown HCBS waiver enrollment by 285% between 2000 and 2006. In 2000, the state served 4,944 individuals through five (5)

HCBS waiver programs. By 2006, the state was serving 14,084 individuals through seven (7) major waiver programs. (Indiana subsequently merged the Medically Fragile Waiver with the AD Waiver, resulting in the current six (6) major HCBS waivers.).

Indiana does have waiting lists for most HCBS waivers. However, a 2006 waiver amendment to add 3,500 slots to the AD Waiver has been submitted to CMS and 650 slots were added to the DD Waiver this year, with a plan to add an additional 1,550 slots to the DD Waiver over a two-year period. **Nursing Facility Transition and Diversion**: Through efforts related to the 2001 CMS Nursing Facility (NF) Transition Grant, the groundwork was formed to transition and divert individuals from NFs to community-based settings. Through the grant, the state collected valuable data by tracking over 100 people who were transitioned back to the community, including demographic information, service and supports (regardless of funding source) necessary to transition these individuals. Outcome information provided Indiana with a new perspective on successful transition processes and shattered some stereotypes regarding traits of a successful transition candidate. This information is now being used to develop transition training and is being utilized as new "transition teams" are formed. **Increase of the HCBS Waivers' Financial Eligibility Limit**: One very recent accomplishment designed to reduce Indiana's historic institutional bias is inclusion of the special income group (income up to 300% SSI) in the AD waiver. This change took effect July 1, 2006. (Appendix K) **Provider Development:** Since recruitment activities began in early 2006, there have been 76 new HCBS providers certified with 39 currently pending for NF LOC waivers and 10 new DDRS providers approved, with 11 applications pending approval. In addition, Indiana is actively recruiting providers of adult day care services, assisted living services, and adult foster care settings. This is accomplished through Program Managers devoted to specific programs, ongoing outreach events

throughout the state, negotiations with facilities considering conversion to new business models, presentations at conferences throughout the state, and funding for marketing materials. By July 1, 2007, Indiana expects to have an additional 150 to 200 providers, including those providing adult foster care, adult day services, self directed care attendants, home health care, homemaker, home modification, transportation, post-transition care coordination, and others with the capacity to serve an additional 1,500 individuals.

Indiana has also recently raised reimbursement rates for AD and TBI Waiver services: a fifteen percent increase for assisted living, attendant care and homemaker services and a five percent increase for other waiver services effective July 1, 2006. Indiana has also amended the Medicaid state plan twice to permit use of TCM to support NF transition activities.

3. **A description of current funding mechanisms, including those that restrict the flexible use of Medicaid funds to support individuals living in the community.**

Indiana has removed several barriers that limited an individual's ability to reside at home or in a community setting rather than in an institutional setting, as noted previously, including implementation of the 300% SSI income limit, expansion of the HCBS waivers and HCBS waiver rate increases. Indiana also utilizes flexible budgeting at the agency level, permitting movement of funds between institutional services and HCBS. Individuals leaving NFs who are Medicaid and AD or DD Waiver eligible may also access funds to provide for start-up costs related to securing and moving to a home. Indiana is proposing to expand this flexible funding by increasing the amount for individuals enrolled in the AD Waiver. The State is also utilizing funds from the Quality Assessment Fee to incentivize providers to build capacity in community living options available to the Medicaid population.

4. **A description of the various systems of care, waivers, and SPAs that are utilized by the State to provide home and community-based supports and services.** **State Plan Services**: Indiana includes an array of state plan services that facilitate community living including TCM, home health services, non-emergency medical transportation, DME, consumable medical supplies and therapies. The state has amended the Medicaid state plan twice (in 2001 and 2003) to permit provision of TCM to individuals transitioning from institutional settings. (Appendix J) **HCBS Waivers**: Indiana is proud of the array of services that are available to a large number of individuals through our HCBS waiver programs. Indiana offers services to a variety of populations through six HCBS waiver programs administered through OMPP, DA and DDRS. (Appendix J) **State-Funded HCBS:** Individuals who are ineligible for the HCBS waivers, awaiting enrollment into a waiver or who require a service or support not covered by Medicaid and that is needed to facilitate community living may access CHOICE or state-funded supports for individuals with MR/DD, (which funds residential and day services, a residential living allowance, crisis assistance, respite, and day services), as appropriate. Access to CHOICE or to state-funded MR/DD supports reduces gaps in service and provides greater flexibility in meeting community-based needs. CHOICE served 10, 275 individuals in 2005 and state-funded MR/DD supports are provided to approximately 9,851 individuals per year.

5. **Current expenditures on long-term and community based care as well as other measures such as the number of institutional beds versus community placements.**
In 2005, Indiana served over 13,700 recipients in the HCBS waivers, expending over $431 million to fund waiver services and over $265.5 million in state plan community-based LTC services (such as mental health services, transportation, hospice, therapies and DME) for these recipients. In 2006, additional growth in waiver enrollees and expenditures is anticipated. Indiana served over 10,000 people through CHOICE in 2005, the 100% state-funded program

designed to support persons in their homes and other community settings. Indiana has experienced a reduction in comprehensive care beds (encompassing Medicare, Medicaid and dually certified nursing facilities) from 58,097 in 1999 steadily decreasing since that time and reaching 50,361 beds in 2004. Indiana is currently has 4,103 ICF/MR beds, of which 286 are located in large, private ICFs/MR, 258 in state operated developmental centers and the remaining 3,559 in small group home. In addition to providing access to community-based services through the State's three MR/DD HCBS waivers, Indiana also provides state-funded community-based MR/DD supports to approximately 9,851 individuals per year.

6. **A description of any current efforts to provide individuals with opportunities to self-direct their services and supports.** In 2001, the Indiana General Assembly passed legislation to add self-directed attendant care services. IC 12-10-17.1 (Appendix I) allows beneficiaries of services through CHOICE and Medicaid HCBS waiver programs to direct their attendant care services. Indiana is in the early stages of developing the infrastructure needed to support and expanded the consumer-directed care (CDC) option. Any individual who desires to provide attendant care services must register with the division, undergo a criminal background check and complete CDC training. Efforts to expand CDC in Indiana have met with recent and rapid success during 2006. CDC is currently offered through the CHOICE program and is expected to begin for AD Waiver enrollees by November 2006. The expanded CDC model includes educational programs, outreach material/programs, informational materials, and training.

DDRS has implemented Person Centered Planning (PCP) for all its consumers. DDRS requires their contracted statewide case management agency to utilize PCP processes as they gather information with the individual for development of the individual service plan (ISP). The

PCP process focuses on identification of what is working/not working for each individual, non-negotiables and future vision in areas such as: relationships, home, work/daily activities, leisure/recreation, community participation, learning, communication, decision-making, challenges and other areas of the individual's choosing.

7. **An overall description of any institutional diversion and or transition programs or processes that are currently in operation.** **Ongoing Transition and Diversion Activities**: Much of the impetus for growth in Indiana's NF transition and diversion movement has grown from the efforts supported through a CMS grant in 2001, which enabled Indiana to initiate efforts through four participating AAAs resulting in the transition of approximately 110 individuals from NF to HCBS settings. In 2002, FSSA established a goal to divert 1,000 individuals from NF admission by June 30, 2003, and by that date, approximately 817 individuals were diverted. Indiana has also acquired experience transitioning individuals from state developmental centers, and has been able to move over 300 individuals from ICFs/MR over the past several years. Indiana continues both diversion and transition activities for NFs and ICFs/MR. Individuals in NFs continue to self-refer to AAAs for transition assistance at a rate of about 200 individuals a year. The existing Transition Team process developed through prior grant-funded transition activities is utilized to facilitate these transitions. In addition, individuals in NFs are one of four groups who have priority access to HCBS waiver enrollment. Indiana also continues diversion efforts, AAAs receive referrals from hospital discharge planners, individuals, their families and others who are either in the hospital or at home and at imminent risk of entering a NF. These individuals also have priority access to HCBS waiver enrollment. **The NF Closure Program**: Indiana is now implementing a formal NF bed closure. The DA is meeting with NFs interested in closing beds and/or entire NFs and assisting the NFs with the development of facility transition

plans. The State is also in the process of expanding and enhancing the transition process. Since January of 2006 a "Transition Team Task Force" comprised of key employees from the FSSA/DA, along with a board certified, fellowship-trained geriatrician who is also a member of the CHOICE Board, have been meeting regularly to define all aspects of Transition Teams for the State of Indiana. This Task Force is currently in the process of writing the "Indiana Transition Team Manual", a comprehensive guide for Transition Teams. Training sessions will begin with select individuals from the AAAs. Simultaneously, an RFP will be released to procure Transition Team services that will be contractually required to provide these services in accordance with the Transition Team Manual. Procurement will also afford an opportunity to receive proposals from a range of interested prospective providers who may propose innovations in transition activities. **FWSDC Closure**: The DDRS is in the final stages of closure of the last State Developmental Center in Indiana. The facility is located in Ft. Wayne, Indiana and will transition the last resident by July 1, 2007.

8. **An analysis of what shortcomings – "gaps" in the system the State intends to address in the demonstration program**: Indiana will be addressing several previously identified gaps through the demonstration program. Previous transition efforts have demonstrated a need to strengthen and formalize the transition process. The demonstration provides an opportunity to implement a strengthened transition program that supports community-based living in independent or small living situations.

Methods to identify transition candidates: Indiana has previously primarily relied upon self-referral for identification of NF residents interested in transitioning to a community-based setting. Indiana is in the process of developing a formalized process to identify transition candidates, using MDS data (Question "Q"), and developing formal outreach and options

counseling processes. Assessment of transition candidates: An improved methods for assessment of candidates and identification of community-based needs has long been desired. Indiana is in the process of reviewing relevant assessment instruments (including the MDS-HC) for selection and implementation.

Stakeholders have identified an ongoing need for increased access to critical supports like in-home services, nutritious meals, on-demand transportation, and appropriate housing – Indiana has already undertaken efforts to increase access and will be focusing on several key supports for the demonstration including development of adult family care homes, adult day services, affordable housing, and on-demand transportation. In addition, the now under development Transition Manual will contain information specific to identification of needed supports and methods to access supports. Indiana will also be making additional funds available to provide for one-time transitional expenses for transitioning individuals (both demonstration and non-demonstration) who are eligible for, or enrolling into, the AD Waiver, raising the amount from the previous $1,000, which may have limited access to community-based settings, to $1,500.

Indiana recognizes that the initial period of community-based living is a critical time period of adjustment for the transitioned individual. Access to clinical oversight after transition is another area that has been identified by case managers and transitioned individuals as a need. Individuals enrolled in the TBI Waiver and DD Waiver have access to this type of service through health care consultation and habilitation services, respectively. Indiana will be addressing this gap by making post-transition care coordination available as a demonstration service and will be amending the AD Waiver to add this service as a permanent transition service. Post-transition care coordination will be available for transitioning individuals (both demonstration and non-demonstration) eligible for, or enrolling into, the AD Waiver, whereby a

nurse is available to the HCBS waiver case manager and transitioned individual, checking on progress and providing as-needed consultation to support success. The planned Care Management Program will fulfill this service need once the program is operational for those transitioned onto the waiver.

Finally, stakeholders have expressed a desire for additional methods to improve quality of services and help participants achieve desired outcomes. Indiana will, as part of this demonstration, fully implement the QA/QI structure described in this application and will be developing person centered planning processes for demonstration participants as well as for persons enrolled in our NF LOC waivers.

9. **An analysis of what collaboration among the various programs in the State is necessary to ensure the success of the demonstration program:** Collaboration between the various divisions of FSSA has increased due to the inclusion of four target groups in the demonstration. The process of planning and executing this application has already resulted in cross-division information sharing and coordination that will continue and accelerate during the demonstration. In addition, inclusion of other state agencies and of consumers, their advocates, HCBS and NF providers and other interested parties is critical to the success of this demonstration. The State has already undertaken activities that substantially strengthen cross-agency and stakeholder participation. The following groups and activities are now in place and the work of these groups will be critical to the success of the demonstration:

- Formal meetings between the DA and the Indiana Housing and Community Development Authority to help identify available housing options for elders and persons with disabilities and to seek priority access to these for demonstration participants.

- Formal meetings between the Indiana Department of Transportation and DA to establish the means whereby FSSA can fund additional transportation for elders and individuals with disabilities, especially for those who are transitioning to the community.
- Formation of a NF Transition Stakeholder group, encompassing consumers and families, advocacy groups, HCBS and institutional providers, and state officials. Indiana expects this group will form various special task forces such as a housing task force and provider development task force.

10. **What systems, procedure and policies are in place to monitor and address, (i.e. track, identify, and correct) deficiencies related to quality assurance for eligible individuals receiving Medicaid HCBS and provide for continuous quality improvement in such services**: There are three systems in place to prevent, track, identify and correct quality deficiencies specific to HCBS: the AAA case management system, division-specific QA initiatives, and the Bureau of Quality Improvement Services (BQIS) system.

The AAA case management system ensures that each individual with LTC needs seeking assistance from the AAAs has access to a case manager (CM), who may be a state-funded CM, or Medicaid-funded CM (TCM or HCBS waiver), as appropriate. CMs are the eyes and ear of the State at the consumer level and as such have responsibilities specific to the various HCBS programs (CHOICE, HCBS waiver, Medicaid state plan). In addition, each HCBS program has specific quality processes specified in Indiana Code and in its policies and procedures. Examples include provider standards and reporting requirements (e.g. DA HCBS CMs must complete face-to-face assessments of enrolled HCBS waiver consumers every 90 days and enter the results of this contact into the case management software system). The Divisions promulgate rules, develop policies and procedures, provide training and ensure completion of various analyses and

reports by Division staff or contracted entities. Designated Division staff collect and analyze data from these various sources and provide the analysis to BQIS. The quality process and interface with the Divisions is described below.

DDRS staff have been providing data and analysis specific to their consumers to the BQIS for an extended period of time. The BQIS is now in the process of incorporating various DA quality activities into this structure in the same manner as for DDRS. The Bureau of Quality Improvement Services (BQIS) was established in January 2001. The Bureau is located within the Division of Disability and Rehabilitative Services (DDRS) and works with both the DD and Aging populations under the FSSA umbrella. OMPP is responsible for and provides oversight of the BQIS. The Bureau has made great progress in developing a quality management system in Indiana. The BQIS has major systems in place for Incident Reporting, Mortality Reviews, Standards Surveying, QA committee structure and Complaints/Investigations for consumers served by DDRS and is now incorporating consumers served by the DA. OMPP oversees all current activities and participates in reviews of initial and annual LOC decisions, reviews denial rates and reasons, reviews Plan of Care (POCs) for trends and timeliness, and reviews all incidents and other input data.

Several major gains have been made in establishing a quality management system since the Bureau of Quality Improvement Services was established.

- Promulgation of 460 IAC 6 in January 2003, which established the standards for all providers of supported living services and supports provided by DDRS. (Appendix G)
- Completed revision to an automated tracking system for complaints/investigations that allows Indiana to better track information and obtain more useable reports to assist in identification of trends and needs.

In October 2003, BQIS was awarded a $500,000 Systems Change Grant through CMS for the establishment of quality assurance and quality improvement systems for recipients of waiver services through the Division of Aging. The grant has allowed BQIS to contract with a vendor to carry out Quality Improvement measures including the development of training processes for Incident Reporting, Mortality Review, and the Provider Standards survey process for the DA. The inclusion of DA within the BQIS structure will be completed by January 2007 and will provide for a comprehensive approach to quality improvement:

- OMPP is the policy making and approval body;
- AAAs and CMs will continue to have frontline responsibility for monitoring quality at the consumer level;
- The Divisions will continue to promulgate rules, develop policies and procedures and conduct specific activities such as consumer surveys and provider monitoring to meet their monitoring responsibilities. Designated Division staff will provide data and analyses to BQIS and participate in the various committees and activities specific to the BQIS quality initiatives;
- The BQIS working with Division staff will monitor, analyze, and remediate specific quality problems as well as develop long-term systems solutions using the committee structure to address incidents, mortality reviews, complaints, surveys and monitoring results, as well trends revealed by data specific to HCBS and impacted services (like hospitalizations, ER visits etc.) for consumers served by the DA and DDRS.

AAA Quality Improvement Efforts: The Indiana Association of Area Agencies on Aging, a collaboration of 16 (AAAs) in Indiana, has also made progress toward self-directed quality management system. A recent initiative, formalized in early 2005, led the AAA network in Indiana to adopt a philosophy of Continuous Quality Improvement that parallels the CMS model

of "Quality in Home and Community-Based Services: The Quality Matrix and Framework (HCBS Quality Framework)." From this quality focus, a philosophy was developed that prompted Area Agencies on Aging in Indiana to look at the following core values:

- Clients are the first priority
- Employees are the strength of the network
- Collaboration is an essential tool in accomplishing a mission
- Recognition that quality statewide systems require uniformity within the network
- Continuous Quality Improvement becomes key to future planning and development in the Indiana aging network

11. **What State legislative and other changes are necessary (and accompanying timelines) to implement the MFP demonstration.** Indiana intends to implement an assessment instrument for use in assessing NF transition candidates and developing initial plans of care for HCBS, that will be used in addition to the pre and post checklists currently utilized. Implementation of an instrument could be accomplished quickly as a paper-based tool and automated during the first half of 2007. Other changes needed to implement the demonstration are already underway including provider development activities (which will be ongoing), development of the transition team manual (scheduled for completion by January 1, 2007) and the transition team RFP (scheduled for release January 2007), development of the transition teams (executed contracts expected to be in place by April 2007 with an effective date of July 1, 2007), and implementation of a strengthened QA/QI system (now underway and ongoing). The MFP demonstration will include a strengthened process for consumer and stakeholder input, which has already begun with the formation of the NF Transition Stakeholder Workgroup, which is now meeting bi-weekly. Staff and consultants are already in place and ready to undertake demonstration

activities. An AD Waiver amendment will be submitted to CMS by early 2006 to add post-transition care coordination as a covered waiver service and to raise the transition expense maximum amount from $1,000 to $1,500. Information technology changes are planned to support the demonstration, including automation of an assessment tool and methods to capture data specific to the demonstration for outcomes analysis and reporting and recording expenditures specific to the demonstration (in the early part of 2007). Legislation will be introduced in 2007 to formalize the options counseling process.

Application Part 2: Demonstration Design (25 page limit)

1.) The Pre-implementation Phase: Indiana intends to complete pre-implementation activities necessary to begin transitions under the demonstration between January 1, 2007 and April 30, 2007. The State is currently modifying existing transition materials for the MFP demonstration, and will ensure materials are available in multiple formats and are consistent with cultural competency and linguistic requirements. A marketing group, which has already been contracted to promote the LTC OPTIONS Program, will also develop new content, such as videotapes of residents who have successfully transitioned, and materials for posting on the Division of Aging LTC OPTIONS website by early 2007. The LTC OPTIONS program is a branding mechanism developed to provide information about LTC services, emphasizing adult foster care (AFC), adult day services, and assisted living, the full array of LTC home care services (including attendant care, homemaker services and home health services), and NF services. This framework is further supported through accelerated program development in key areas of support for community-based living: affordable housing, health care delivery, nutrition and reliable on-demand transportation. The FSSA DA is meeting on an ongoing basis with the Indiana Housing and Community Development Authority to identify suitable residential options (e.g. senior housing) for demonstration participants. Consumers, family members, advocates, HCBS and NF providers have attended the NF Transition Stakeholder Workgroup meetings and are developing the structure of taskforces or other groups they determine are necessary to support MFP NF transitions. This Workgroup will continue to meet throughout the five-year grant period. The DA is also facilitating the implementation of additional transportation services for "on-demand" transportation to be administered by the AAAs in SFY 2008.

FSSA has set aside funding for diversion slots for State Fiscal Years 2007-2009 and contacts with hospital discharge planners, supplemented by provision of program materials, have been initiated. As stated previously, Indiana has also been transitioning individuals from the State developmental centers. The last remaining developmental center in Ft. Wayne is scheduled to close June 30, 2007. As a result of these activities, Indiana has an existing infrastructure specific to transition coordination activities. Indiana plans to strengthen the transition process by procuring for MFP transition teams, who will serve as the contact points for initiating transition activities. The teams will initially be operated by AAAs and will consist of a registered nurse (RN) and a social worker who will coordinate transition efforts with a case manager transition specialist and LTC Ombudsman. Individuals with MR/DD who meet NF LOC will be served by a MFP transition team with the inclusion of a BDDS transition service coordinator. The State expects to release an RFP for transition team services by January 2007 and by April 2007 expects to have executed contracts with an effective date of July 1, 2007. The State also expects to have a transition team manual and training materials prepared by January l, 2007. If the procurement is not completed before initiation of transitions under this demonstration, the existing AAA administered transition team process will be utilized.

In accordance with Indiana Code, all individuals seeking admission to an Indiana nursing home, and who are a "new admission", must participate in the Pre-Admission Screening (PAS) process irrespective of how the NF services will be reimbursed. Indiana will enhance its existing institutional screening and assessment process in the following year developing an Options Counseling tool that will be completed by April 2007, and will seek legislation during the 2007 legislative session, which will amend the current PAS language to reflect HCBS options counseling.(Current legislation in Appendix H.) In addition to the PAS/Options Counseling tool,

FSSA is in the process of identifying an assessment instrument to assess potential candidates for the MFP demonstration who are currently residing in a NF. IN is strongly considering the Minimum Data Set – Home Care (MDS-HC), which will more accurately reflect an individual's functional abilities and limitations and better assist in the development of an appropriate plan of care. Individuals responsible for administering the selected assessment instrument will be trained by state staff or designee. A BDDS tool will supplement the selected assessment instrument for individuals with MR/DD preparing to leave a NF.

Indiana's Office of Medicaid Policy and Planning (OMPP) uses Minimum Data Set- LTC (MDS-LTC) resident assessment data from Section Q, question 1.a. of the Long-Term Care Facility Resident Assessment Instrument to identify NF residents expressing an interest in returning to the community. This data is being utilized to develop an "interest list" of individuals who are likely candidates for NF transition and options counseling. This data is maintained in the Indiana State Department of Health (ISDH) data repository, and FSSA accesses this data on a regular basis, through reports developed for OMPP. This, along with Resource Utilization Groups (RUGS) data for individuals in NFs is reviewed to better understand resident needs, including those who have expressed a desire to return to the community.

There are currently 1,670 individuals with MR/DD residing in NFs. The planned NF closure activities and additional options counseling along with the Transition Team coordination is expected to accelerate transition opportunities for individuals with MR/DD in NFs. This new approach to NF transition makes this an ideal opportunity to include individuals with MR/DD. Some of the individuals who will not require services specific to the DD Waiver may access services through the AD Waiver if deemed appropriate for, and selected by, the individual.

Indiana already utilizes a single appropriation, global financing model for Medicaid LTC appropriations. FSSA policy results in annual budgeted amounts for NFs and for the NF-level of care HCBS waiver programs, and FSSA's rebalancing initiatives are reflected in the annual budgets. Funding of waiver slots for individuals with MR/DD residing in NFs is mandated and is included in the FSSA budgeting process. Individuals with MR/DD may elect enrollment in either the AD Waiver or DD Waiver at the option of the individual and given their needs can be met appropriately in the selected waiver. Individuals with TBI meeting NF LOC will have the opportunity to enroll into the AD Waiver if their service needs can be met through this waiver. An interdepartmental-interagency assessment is being conducted regarding the needs of all persons with TBI in Indiana – as such, it is not certain at present how the TBI Waiver will be modified in the future. Finalized plans to address this population's full array of needs is targeted for October 2007.

Indiana provides an array of services to meet the LTC needs of individuals in community-based settings including Medicaid state plan services, HCBS waivers, and Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE)-funded services (state-funded services). Indiana previously amended the Medicaid state plan to permit use of targeted case management for individuals being diverted or transitioned from NFs. Indiana also includes a community transition service in the AD Waiver providing for up to $1,000 in transition expenses for individuals leaving NFs. The money may be used for security deposits, utility turn-on fees, essential furnishings, etc. Individuals with MR/DD may also receive up to $1,000 in transitional living expenses from supplemental state funding, which may be used when housing expenses exceed the amount available to the consumer from their SSI

check and/or other sources of income. FSSA will increase the transition expense amount for the AD Waiver to provide up to $1,500 for permitted transition-related expenses.

Indiana is also in the process of implementing a consumer-directed personal attendant option for the AD Waiver. As of September 1, 2006, 112 AD Waiver enrollees had expressed an interest in hiring and self-directing their attendants. The self-directed attendant care option is expected to increase access to providers for individuals selecting this option in the AD Waiver, by increasing attendant care provider capacity. Individuals transitioning from NFs entering the AD Waiver who successfully complete the consumer training component may utilize this option. This option will be operational in the AD Waiver by November 2006. Indiana expects to make CDS more broadly available by including self direction as an option in the DD Waiver in SFY 2009 and by making additional services available for consumer direction in the AD Waiver in SFY 2009. Individuals may select a surrogate decision-maker in order to exercise this option when necessary and will also benefit from the services of a fiscal intermediary.

Because the first year after discharge is a critical time period as the transitioned individual deals with a new level of independence, Indiana will make post-transition care coordination available as a demonstration service and add this service to the AD Waiver. Post-transition care coordination will encompass coordination of a participant's health-related needs provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN), such as ensuring timely access to preventative care, access to in-home services necessary to address medical needs, and provision of consultation to the individual and individual's case manager to address health-related concerns and follow-up on medical events such as hospitalization. A similar service is already available on the TBI Waiver (health care coordination) and through the residential habilitation service on the DD Waiver.

Indiana, like many other states, has faced challenges in ensuring an adequate supply of HCBS providers, especially for respite care, attendant care, adult day care and certain residential options. Indiana has recently raised reimbursement rates for AD and TBI Waiver services: a fifteen percent increase for assisted living, attendant care and homemaker services and a five percent increase for nearly all other waiver services effective July 1, 2006. OMPP and BDDS are currently working with CMS with the restructuring of the reimbursement for the MR/DD Waivers. The three divisions worked very closely during the FSSA AD and TBI Waiver and CHOICE adjustment decision making process to ensure that providers were being reimbursed consistently across all services. There have been 76 new provider applications received by the Provider Waiver Specialist who reviews these applications for FSSA DA, with 39 applications currently pending. There have been 10 new certifications and 11 applications are pending review by the DD Provider Specialist. In addition, Indiana is actively recruiting providers of adult day care services, assisted living services, and adult foster care settings with three or less consumers residing in the home. This is accomplished through Program Managers devoted to specific programs, ongoing outreach events throughout the state, negotiations with facilities considering conversion to new business models, presentations at conferences throughout the state, and funding for marketing materials. By July 1, 2007, Indiana expects to have an additional 150 to 200 providers, including those providing adult foster care, adult day services, self directed care attendants, home health care, homemaker, home modification, transportation, post-transition care coordination, and others with the capacity to serve an additional 1,500 individuals.

Indiana is currently revising their HCBS Quality Framework for the NF level of care waivers using a CMS grant. The redesign of the QA framework is based upon the Centers for Medicare and Medicaid Services HCBS Quality Framework for the development of quality

assurance/quality improvement for the home and community-based waivers. The QA/QI system is described in Item 9.

The State of Indiana is planning upgrades to the IT infrastructures on 3 different fronts: an online Ombudsman software tool (November 2006), an online assessment software system, and a new Case Management software suite. The new Ombudsman tracking tool is a state-of-the-art real time web-based system that Ombudsman around the state will enter data into and which will provide immediate access to the data repository. The second system is a real-time web-based assessment instrument. The current manual assessment tool screens for NF LOC but does not address community-based needs. The State is considering use of the MDS-HC, with manual implementation of the selected instrument in early 2007 and completion of the real-time web-based version by early in 2007. The third initiative, an enterprise case management system, will begin with requirements gathering in early 2007. The FSSA, including the Division of Aging, currently uses a client-server software system (INsite) that is outdated and does not include all of the necessary and desirable functionality. Additional IT initiatives are being implemented or planned to support enhanced QA/QI processes, the new assessment tool, and implementation of the consumer directed service option, including support of the FI services and use of a telephony function to verify services are provided in accordance with an individual's plan of care. Improvements have previously been made to support APS, PAS, Ombudsman involvement and oversight, and fair hearings activities.

Indiana has an existing system for tracking outcomes for persons transitioned from NFs. FSSA's contractor, Milliman Inc., produces ongoing quarterly reports that include information about services utilized to maintain independence in the HCBS setting, as well as an enclosure which shows how long the individual resides in the community after transition.

Further systems development will be included to track quality outcomes. Data including satisfaction surveys, audits, dates of hospitalizations and deaths, mortality reviews, and data developed through the planned Care Management Program, will be utilized to track quality outcomes of transitioned individuals. Reports by post-transition care coordinators, consumer complaint calls, APS reports, incident reports, HCBS waiver ninety-day case manager reviews, and BQIS client satisfaction surveys will be reviewed on an ongoing basis by the MFP demonstration project director and identified issues along with analysis and findings will be provided to the appropriate QI/QA committee(s). In compliance with the proposed Aging Rule, the DA is enhancing the Quality Assurance system to identify issues timely, especially to prevent or rapidly address suspected or verified incidences of abuse, neglect, or exploitation for individuals who are receiving benefits through the Division. This project also creates a follow-along measurement of services/plans and will provide information for senior Division staff to improve delivery of services. As the State progresses in its effort to increase access to medical and support services in HCBS settings, the responsibilities of the Ombudsman will increase and diversify and additional monies in the DA budget have been included to increase Ombudsman staffing therefore improving consumer access to persons who can receive their complaints and advocate on their behalf.

FSSA currently contracts with a vendor (EDS) to conduct audits of 10% of providers annually on a random basis. FSSA intends to alter this system and is currently procuring a contractor for the development of a system in which data will be mined to identify "outliers", which will then form the basis for a more comprehensive review. The review will emphasize validation of all aspects of quality, becoming more focused on the health outcomes of the individuals.

Indiana is in the process of developing cultural and language competency requirements specific to the NF transition process, which will be utilized for outreach and marketing materials developed by FSSA. Existing requirements for DA programs include preparation of LTC OPTIONS materials in Spanish and ADRC responsibilities to ensure translation and TTY services are available. Transition Team social workers will be responsible for ensuring these needs are met for demonstration participants. For less frequently used languages, translation needs will be addressed through FSSA subscription to assistance through a language line.

Indiana has undertaken a comprehensive approach to gaining collaboration from the many stakeholders impacted by existing LTC initiatives and will further develop this approach for the proposed demonstration. The FSSA DA has been working with a stakeholder group since February 2006, specifically for purposes of refining the aging reform initiatives around capacity. This initial stakeholder group requested that the TBI population be included as a target group for NF transitions. This group has now evolved into a NF Transition Stakeholder work group, and includes a coalition of provider associations, and representatives from a range of organizations to participate. Invitees include ARC, NARF, Indiana Brain Injury Association, , the Alzheimer's Disease Task Force, Protection and Advocacy Services, ISDH Minority Health, AARP, IN211, Indiana Housing and Community Development Authority, Indiana Institute on Disability and Community, the Community Consumer Advisory Council, the CHOICE Board, Vocational Rehabilitation, and other groups, as well as individual consumers and/or family members. Two meetings have been held and will continue bi-weekly.

2.) The Implementation Phase: Indiana will be including four target groups comprising three demonstration populations in the MFP demonstration:

- Elders who meet NF LOC and who are eligible for the AD Waiver;

- Adults with physical disabilities who meet NF LOC and who are eligible for the AD Waiver, including adults with TBI who meet NF LOC and who are eligible for the existing TBI Waiver or the Aged and Disabled Waiver; and
- Adults with MR/DD who meet NF LOC and who are eligible for the DD Waiver or Aged and Disabled Waiver.

While individuals with mental illness are not a targeted demonstration population, individuals residing in NFs who also have a diagnosed mental illness will be among those who can participate in the demonstration.

Indiana will transition individuals who have received institutional care for a minimum of six months in order to qualify for the demonstration. Institutional care may include hospitalization and institutional rehabilitative services as well as NF services, if there are no community days of care between each period of institutional care (e.g. the person transitioned from one institutional setting to another without being discharged to the community). The MFP demonstration will be operated on a statewide basis – individuals from the targeted groups and residing in any NF in Indiana are candidates for participation.

Indiana envisions a flexible, comprehensive and easy-to-use access system for persons seeking to leave NFs. While the official point of contact for transition referrals will be the local AAA or ADRC, all of Indiana's potential points of contact, including the Transition Teams, will accept inquiries concerning the MFP demonstration. Individuals who contact their AAAs, ADRCs or Bureau of Developmental Disabilities Services (BDDS) offices will be provided with basic transition information. Individuals seeking to leave NFs will be afforded their choice of qualified residential settings, subject to availability and feasibility. Qualified residential settings consist of the following: a home, which encompasses the individual's own home or family home

a shared home with no more than four unrelated housemates, or an apartment, including apartments available in HUD subsidized housing complexes or congregate housing complexes that accommodate elders and individuals with special needs; an adult foster care home where no more than four unrelated individuals reside; and residential habilitation home for four or fewer unrelated persons.

Indiana does not intend to make assisted living facilities available to individuals in the demonstration because we do not believe such facilities as licensed in Indiana meet the intent of the demonstration.

Individuals participating in the MFP demonstration will have access to qualified HCBS, a specific additional service included in the demonstration as well as other sources of services and supports available to persons with LTC needs. Qualified HCBS include Medicaid state plan services such as home health services, DME and TCM; HCBS waiver services provided through the AD Waiver, TBI Waiver, and DD Waiver; and other sources of services and supports, which include: the Community and Home Options to Institutional Care for the Elderly and Individuals with Disabilities (CHOICE – a state-funded program), Older American Act services, food stamps, housing assistance, services funded by other public programs including VR or the VA, faith-based services and "volunteer" assistance. In addition, Indiana will increase transition expenses from the current maximum of $1,000 in the AD waiver up to $1,500. This service is a qualified HCBS. Demonstration services will consist of post-transition care coordination for participants eligible for or served by the AD Waiver and will be available to all transitioning individuals (demonstration participants and non-participants). Indiana will not be including supplemental services in the demonstration.

Indiana expects to transition approximately 2,600 individuals from NFs between 2007 and 2001, an estimated 1,039 of whom will qualify for the MFP demonstration (e.g. they choose to leave a NF, utilize a qualified residential option, and have six months or more of qualifying institutional residency). Indiana will begin to transition some of the 2,600 individuals from NFs as early as February 2007. Access to the MFP demonstration grant will assist Indiana in both accelerating NF transitions and developing a robust program design. The demonstration design, including qualified HCBS is summarized in the State Profile and Summary of Project.

3.) Anticipated requests for the waivers necessary to operate its program, including modifications to existing waivers and State plan amendments. Indiana anticipates a need for the amendments specific to the demonstration, including the addition of post-transition care coordination; the increase the maximum amount for transition expenses from $1,000 to $1,500; and TBI Waiver renewal is due December 2007, which might include amendments specific to the MFP demonstration following assessment by the TBI workgroup, but which have not yet been determined.

4.) A description of methods that will be used by the state for each fiscal year to increase the dollar amount and percentage of expenditures for HCBS. The Division has a well developed aging reform agenda, with initiatives well underway to increase capacity, increase access to services, rebalance the LTC funding, and to make the public aware of the shifting of focus in LTC service provision in Indiana from NF to HCBS. Indiana has developed a NF closure fund to incentivize provider closure of NF beds/facilities and encourage development of alternative, community-based residential options. As a result, Indiana has transferred a portion of NF dollars, through the SFY 2007 budget process and the 08-09 biennial budget forecast, to the HCBS waivers in order to support transition of individuals from NFs to community-based

residences. FSSA's goal is to "rebalance" LTC by shifting LTC dollars to the community. The DA's goal is to achieve a 41% NF LOC HCBS expenditures to 59% NF expenditures distribution by 2009 from an existing 23% NF LOC HCBS to 77% NF distribution.

5.) A list of proposed benchmarks to establish empirical measures to assess the States progress in rebalancing its long-term care system. The proposed benchmarks must conform to the requirements specified in Section 6071(d)(4)(a). Proposed benchmarks are:

1. State Medicaid support for home and community-based long-term care services:

2007=$545,875,054 2008=$656,596,017 2009=$753,712,892 2010=$812,063,049

2011=$857,664,150 Total=$3,625,911,162

2. Numbers of eligible individuals assisted to transition to qualified residences:

2007=129 2008=345 2009=235 2010=180 2011=150 Total=1,039

The State is also interested in discussing an additional benchmark specific to provider capacity and quality prior to finalizing the agreement.

6.) Processes for how the State intends to target and recruit individuals to transition from institutional settings to the community, including specific strategies and procedures. The State intends to target and recruit individuals to transition from institutional settings to the community with specific strategies and procedures. General outreach activities will consist of

Conducting meetings and distributing materials to NF providers, hospital discharge planners, residents and their families; conducting meetings and distributing materials to other key stakeholders; making a 1-800 MFP demonstration contact number available for inquiries; and

posting materials on the LTC OPTIONS website and seeking "links" to the website from stakeholder websites.

Prospective transition candidates may be identified in one of following four ways: a new NF resident who expresses a desire to transition at some time back to the community, as identified during assessment by the NF or a NF resident who has entered a hospital and who is expected to return to a NF but who expresses a preference to the hospital discharge planner to return to a community-based setting; a resident who has indicated a desire to return to the community and for whom this indicator is entered in the MDS, Question Q; a resident residing in a NF participating in the NF closure program (whereby one or more NF beds are scheduled to close); and/or an inquiry received from a resident or their family through any existing referral entity. NF transition inquiries received from individuals, family members or others will be funneled to the appropriate ADRC or AAA (in areas where the ADRC is not yet operational). Individuals will be provided with basic information and connected with their local transition team for scheduling and completion of a face-to-face assessment with the NF resident.

For individuals residing in NFs with anticipated bed closures, the Transition Team (TT), will participate in meetings at the NF and/or teleconference calls as often as the resident relocation process dictates to provide options counseling and to assist with transition of any individual expressing a desire to move to a community-based setting. The team will also proactively identify prospective candidates for transition by reviewing the NF closure list of resident information and MDS data and will offer options counseling to residents identified in this manner. For individuals residing in NFs that have no anticipated bed closures, the case manager transition specialist will review the list of individuals newly admitted to the NF each week, the MDS data, and referral calls, to identify candidates for options counseling and transition assistance.

The specialist will relay this information to the Transition Team (TT). The TT will visit the individual and complete options counseling and an assessment to assist the individual in making an informed choice regarding the feasibility and time frame for transition to a home and community-based setting. The LTC Ombudsman will also be an important part of the transition process, assisting the TT as needed and checking with the individual to ensure concerns and needs are being addressed. If transition is feasible and desired by the individual, the TT will start the transition process. The TT will collaborate closely with nursing facilities to ensure that planned discharges occur timely. Legislation will be introduced in 2007 to formalize the options counseling process. In addition, all participating individuals will be provided with written information describing the MFP demonstration program, the research design and objectives, and any critical and upcoming or anticipated changes to the program, covered HCBS or demonstration services that could impact the individual. These include, but are not limited to, any changes in the MFP demonstration design and scope of services; dates of renewal and/or anticipated amendment of specific HCBS waivers, purpose of a renewal or amendment, anticipated changes to be contained in the renewal or amendment and scope of possible changes that States may make when submitting renewals or amendments; anticipated changes in scope of coverage of Medicaid state plan HCBS; and changes in administration of any HCBS programs and potential impact on individual. The individual's consent will be secured for participation in the MFP demonstration.

Outreach activities designed to ensure all NF residents are informed of their LTC choices will include: making face-to-face visits with NF residents and families to provide general information for residents who are unsure if they wish to transition; providing video tapes of consumers and their families who have successfully transitioned from NFs to the community to

interested residents and families; and educating ombudsman, HCBS case managers, NF discharge planners, hospital discharge planners, and BDDS Service coordinators regarding the MFP transition options and process.

In order to ensure information and services specific to the MFP demonstration is readily available Indiana will: develop written materials describing the MFP demonstration including points of access, the intake process, eligibility process, transition process and available community-based services and supports; post MFP demonstration information, which will be available in multiple formats and available for download, on the LTC OPTIONS website; develop a videotape featuring individuals who have successfully transitioned from NFs; conduct an outreach campaign utilizing community presentations and NF resident presentations; ensure entities who are likely to know of candidates for transition (Independent Living Centers, NFs, state agencies) and all potential points of contact have access to these materials and have received training regarding referral and utilization of these resources; and make LTC OPTIONS Program materials/counseling available at time of hospital discharge to short term NF stays.

Indiana plans to strengthen the transition process by procuring for MFP transition teams for individuals at NF LOC. Indiana envisions a flexible and comprehensive approach that will be easy for individuals to access. The only criteria the state will impose for participation in the MFP demonstration are: an expressed interest in leaving a NF; and access to sufficient services and supports, formal and informal, to meet the community-based needs of the consumer.

7.) A description of the cross agency and cross service delivery system collaboration that will need to occur to ensure success of the State's transition program. Indiana has solicited participation from a wide range of state agencies, service sector and advocacy groups, as well as input from elders and individuals with disabilities. The formation of workgroups was described

previously. A number of state agencies are involved in gathering information and providing input for the MFP demonstration. Because the demonstration will include four target groups served by three divisions of FSSA (OMPP, DA and DDRS) and involvement of other divisions (Division of Family Resources – Medicaid eligibility, food stamps) and state agencies, (for example, the Department of Health, Department of Transportation, and Indiana Housing and Community Development Authority) for key functions, the design seeks to, whenever feasible and advantageous, utilize a single approach for demonstration activities. BDDS, within the DDRS, has established opportunities for caregiver training through the Department of Workforce Development and Indiana Economic Development Corporation. Because Indiana has a single umbrella agency, FSSA, (Appendix B) under which most of the impacted divisions reside and under which the agency budget is controlled, development and financing of needed system improvements is streamlined. In addition, legislation effective July 1, 2006 authorized the formation of the Division of Aging (DA), which provides a greater focus on the needs of elder Hoosiers. Legislative allocation to a single LTC budget provides the flexibility needed by FSSA to rebalance funding between NF and HCBS for the aged and disabled population.

FSSA has developed a QA/QI model that is interdepartmental and draws from outside expertise as well. The proposed care management program being developed for aged, blind and disabled recipients enrolled in the State's PCCM program is one example of a model of care that seeks to improve health care outcomes by addressing care issues across delivery systems. Indiana plans to continue to develop cross-agency and cross-system capabilities in the areas of access, stakeholder input, program design, funding and QA/QI.

8.) A description of the "qualified home and community-based program" which will be available to individuals following the year they receive services through the demonstration

program. Demonstration participants will be enrolled into one of three HCBS waiver programs following the demonstration period – the AD Waiver, TBI Waiver (or alternative TBI program that provides comparable community-based services), or DD Waiver, based on need for waiver services, eligibility, and individual choice. They will remain in these waiver programs as long as they continue to meet the eligibility criteria and desire continued enrollment. These individuals will continue to receive an array of HCBS funded by Medicaid state plan, HCBS waivers, CHOICE, OAA and other funding sources.

9.) A description of the State's preliminary design of a proposed Quality Management Strategy that encompasses both the program participants and the qualified home and community based program that will be in place when the demonstration is finished.

The Family and Social Services Administration (FSSA) is committed to the continual improvement and enhancement of the quality management strategies developed by the Bureau of Quality Improvement Services (BQIS) established in 2001. In 2003, FSSA received a Systems Change Grant to implement/enhance the quality assurance and quality improvement systems for the home and community-based waivers with a nursing facility level of care. The efforts to enhance those systems will continue in order to have a fully functioning, integrated QA/QI system that encompasses FSSA's strategic vision of serving more individuals in the community.

BQIS is housed within FSSA. BQIS has implemented several processes through which to monitor the quality of services and outcomes for consumers, including a risk management program, consumer complaint process (utilizing a toll-free complaint phone number) and formal surveys of HCBS consumers and providers. Incident Reports (IR) are actively reviewed and tracked, and reports are provided to the BDDS field staff on a weekly basis requesting follow up and action. These follow ups continue until there is resolution, or the IR is forwarded to the

Sanctions committee to take corrective action and/or make recommendations for policy changes. The same system is currently being implemented for the waivers administered through DA through a CMS grant to BQIS. As part of the risk-management process, BQIS developed the following committees to provide oversight and recommendations in the development of the QA/QI system, building on an initial and very successful committee structure developed specific to programs for persons with DD, but which is now in the process of being expanded to address the needs of all persons receiving LTC services:

- The Consumer/Community Advisory Committee (CCAC), which provides consumer/community input and oversight for all aspects of the QA/QI system and which has responsibility for review of data analyses;
- The Risk Management Committee (RMC), which reviews aggregate data collected from the incident reporting system;
- The Mortality Review Committee (MRC), which reviews the circumstances surrounding the death of a HCBS recipient, develops recommendations for systems changes and identifies training needs;
- The Standards Committee, which is responsible for developing provider standards specific state rules for HCBS;
- The Sanctions Committee, which serves as a forum to discuss policy, provider and non-compliance issues and to provide recommendations based on findings of fact resulting from investigations; and
- The Quality Improvement Committee, which is responsible for oversight of the QA/QI system.

BQIS provides reports and data to OMPP and the Divisions for review, analysis and the development of recommendations. BQIS then provides this information to the appropriate committee(s), and facilitates committee meetings. Recommendations resulting from the data, complaint call and survey analyses and committee meetings are provided to the Quality Improvement Executive Committee for action, including the development or revision of policies and procedures and identification of training needs. This committee structure will be utilized for completion of on-going system improvements and quality assurance oversight.

Organizationally, BQIS is housed within the Division of Disabilities and Rehabilitation but continues to provide the quality improvement support for the waivers implemented through the FSSA DA. The goal of FSSA is to continue to structure quality oversight and assurance that is conducive to meeting the QA/QI needs of all divisions. FSSA is committed to developing a more robust quality assurance and improvement plan that will encompass the entire continuum of long-term care. As such, each division responsible for long-term care services will be required to inventory activities related to the data collection (discovery), remediation and quality improvement efforts currently underway. A uniform tool will be used by the divisions, which will be organized along the HCBS Quality Framework domains and will include the following: existing quality assurance processes; required HCBS waiver assurances (using the CMS Worksheet for Reviewing State's Evidentiary Information and the Guide for Assisting States in Identifying Evidence); type of data collected (related to providers or to consumers); reliability, timeliness and methods of data collection; process for acting on data collected; and interventions implemented.

The inventory will serve to highlight the areas that are functioning well, need improvements, lack integration or have been omitted entirely. Of particular interest to state officials is the

State's capacity for serving individuals in their homes and communities: this area will require particular attention as the state seeks to grow capacity throughout the state.

A planning and analysis work group, comprised of lead staff from the three divisions will be responsible for the completion and review of the inventory tool. This inventory will then be provided to the Quality Improvement Executive Committee for review and identification of changes needed and referred to the Consumer/Community Advisory Committee or the Standards Committee, as appropriate, for action. Such actions will include performance outcomes development, reporting standards development and systems enhancements for the collection of the data; development of methodologies for the on-going monitoring and analysis of the data; and identification of mechanisms to affect changes within the long-term care continuum based upon the data collected. Both committees include representation by advocates, consumers/family members/representatives, providers and state staff. As part of the quality management strategy, additional manuals are being developed in order to build in requirements for delivering quality services. Manuals already developed and in use include a transition best practice manual and instructional manuals specific to the CDS option. Manuals under development include the Transition Team Manual and the HCBS Waiver Manual. Training will be provided specific to these manuals.

Transition Teams will be an integral part of the quality assurance plan. Team members will be responsible for maintaining contact for the first four to six weeks after transition with the waiver case manager and transitioned individual to ensure that the individual is functioning well in the community and is able to satisfy their own personal goals. Transitioned individuals will receive post-transition care coordination services after discharge from the transition team. The waiver monitoring system will be automated such that the data can be collected, synthesized and

stored for retrieval by staff in order to analyze and identify patterns and to take timely, appropriate action to correct problems as they are identified.

FSSA is also developing a care management program for aged, blind, and disabled members designed to improve the health outcomes of special needs consumers. An RFP for the Care Management Program is being prepared for release with program roll out scheduled for the Fall of 2007 and full implementation by approximately 2009. Once implementation is complete the post-transition care coordination will likely be unnecessary, as the Care Management model will dovetail this service. Because the date for implementation of Care Management for HCBS waiver enrollees is not yet determined, post-transition care coordination will remain available as a demonstration service throughout the grant period and will be added to the AD Waiver via an amendment request.

The CM is responsible to ensure that the consumer's needs continue to be met through the combination of self-directed attendant services, "traditional" waiver services, state plan services and other services and supports (formal and informal) utilizing ninety day reviews of the individual's continued preparedness to utilize this service option. Consumers, CMs and participating providers receive a manual and comprehensive training specific to the consumer directed option, if this is part of their plan of care . Additional quality oversight for this option includes a telephony service that reports provider timesheets to the fiscal intermediary to assure that individuals are receiving the consumer-directed services on their plan. Indiana will continue to use the Participant Experience Survey (PES), in addition to the Core Indicator Project for the DD waiver, and a case manager questionnaire on the AD Waiver, and consumer complaint calls as part of their quality management program to provide State officials with information about

program participants' experience with the services and supports they receive under the HCBS waivers. FSSA staff are conducting PES with twenty percent of HCBS waiver recipients.

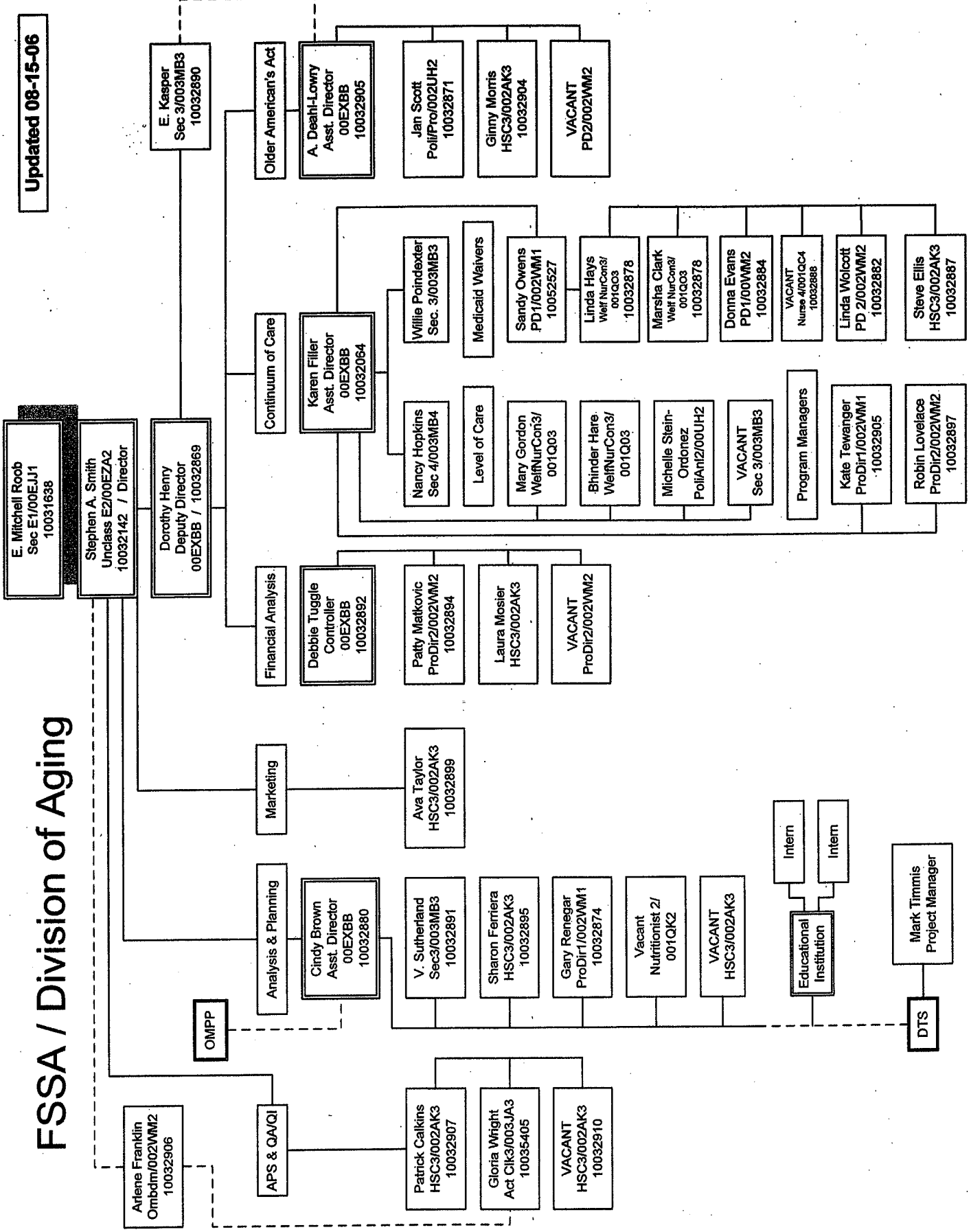
10.) An overall description of the State's current quality management system, where the gaps are and what will be developed and implemented in order to ensure the health and safety of consumers who are transitioned and the continuous improvement of HCBS and institutional care. The FSSA, Bureau of Quality Improvement Services has identified gaps in the existing system including a delay in implementing incident reporting for individuals enrolled in the AD and TBI Waivers, a need for mortality reviews for elders and individuals with physical disabilities served by FSSA and enhanced consumer surveys and provider monitoring. The BQIS division is working with the DA to implement the same process used for individuals served by DDRS for individuals served by the DA: an incident reporting system, including mortality reviews, an improved HCBS waiver provider monitoring process, enhanced consumer satisfaction surveys, and APS incident report follow-up. Incident reporting has been implemented for individuals served by the BDDS (e.g. individuals with MR/DD) and will be implemented for individuals served by the DA (including individuals enrolled in the AD or TBI Waivers) by a contractor in January 2007. Incidents, as defined in 460 IAC1.2-8-2, are required to be reported to DDARS at the time of the incident or upon becoming aware of an incident, unless superseded by other requirements such as abuse reporting. Web-based incident reporting is being implemented. Indiana is also in the process of contracting for HCBS waiver provider certification and provider monitoring for the HCBS waivers. The DA will use the BQIS Guidelines – Pre-Transition Quality Assurance Checklist to assist in ensuring supports and services are in place to meet an individual's needs upon discharge from an institutional setting. The ability to locate service providers quickly for back-up or replacement purposes is essential

for individuals residing in the community who are dependent on in-home supports. A registry of personal attendants will be maintained by the FI for the consumer directed care providers. The AAA pick lists also serves as searchable databases, as will the LTC OPTIONS website, which may be accessed at: http://www.in.gov/fssa/elderly/options/.

11.) A brief description of barriers that prevent the flexible use of Medicaid funds so that money follows the person and a summary of strategies the state will employ under the demonstration to eliminate those barriers: Indiana already utilizes an integrated budgeting process and can move NF and alternative HCBS waiver funding at the beginning of each FY to permit money to follow persons leaving NFs. FSSA allocations specific to the MR/DD population residing in NFs are also developed through the annual budget review and forecasting process and this method will continue to be used to address this target population.

12.) An analysis of how the State will use or enhance existing IT systems to address identification of MFP participants. Identification of MFP participants: NF PAS offers an opportunity to identify candidates for diversion when anticipated length of stay in the NF is short-term. Projected length of stay is a field on the PAS Form, which is captured electronically and can be utilized to identify NF residents who expected to be discharged in the short-term and who may need transition assistance. MDS data is gathered by the NF is retrieved by FSSA/DA staff to identify NF residents expressing a desire to return to the community as another group of potential MFP participants. Indiana is planning to implement an assessment instrument (MDS-HC), that will further assist in identifying which potential MFP participants can be served safely in the community. This instrument will be available electronically following initial implementation. **Financial information for reporting enhanced FMAP:** Participants will be identified by a specific level of care code in Indiana AIM designed to distinguish MFP

participants from individuals transitioning from NFs who will not be participants (because they do not meet the MFP requirements). These codes will be enabled for future use, with an anticipated date of availability of February 1,2007. Participants will be tracked through reports generated on a monthly basis. Codes will be developed for categories of individuals (non-MFP is one category, non-MFP another category within the following list): DD moving to DD waiver – transitioned, non-MFP or MFP; DD moving to AD Waiver- transitioned, non-MFP or MFP; TBI moving to AD Waiver- transitioned, non-MFP or MFP; TBI moving to TBI Waiver - transitioned, non-MFP or MFP; Aged moving to AD Waiver- transitioned, non-MFP or MFP; Disabled Adult moving to AD Waiver – transitioned, non-MFP or MFP. OMPP will be generating data reports to allow Indiana to track the qualified expenditures as they apply to the MFP participants. DA is researching the system interface issues between INsite and Indiana AIM but does not anticipate any major issues accomplishing this. **Assessment data to monitor transitions:** HCBS waiver assessment and plan of care data is gathered by the AAA or HCBS waiver case manager and transmitted electronically to FSSA. PES and provider monitoring data is accessed by BQIS. BQIS shares these outcomes with the appropriate divisions to analyze outcomes to identify necessary system changes and to provide targeted assistance to providers in areas identified for improvement. IT initiatives that impact identification and QA/QI issues for MFP demonstration participants include: implementation of software-based assessment instrument (MDS-HC); implementation of the new Case Management System; changes to accommodate enhanced QA/QI Program Monitoring; changes needed to support the expansion of CDC services; and changes needed to support enhanced adult protective services investigations, preadmission screening and the hearings and appeals system.


Updated 08-15-06
FSSA / Division of Aging
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10031638
Stephen A. Smith
Unclass E2/00EZA2
10032142 / Director
Dorothy Henry
Deputy Director
00EXBB / 10032869
E. Kasper
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Older American's Act
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Welf NurCon3/
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Nurse 4/001QC4
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Linda Wolcott
PD 2/002WM2
10032882
Steve Ellis
HSC3/002AK3
10032887
Nancy Hopkins
Sec 4/003MB4
Level of Care
Mary Gordon
WelfNurCon3/
001Q03
Bhinder Hare
WelfNurCon3/
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10032897
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00EXBB
10032892
Patty Matkovic
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10032874
Vacant
Nutritionist 2/
001QK2
VACANT
HSC3/002AK3
Intern
Intern
Educational
Institution
Mark Timmis
Project Manager
DTS
OMPP
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Ombdm/002WM2
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VACANT
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Key Staff Dedicated to the MFP Demonstration Program				2007	2008	2009	2010	2011
Division	Title	Name	Description of Roles and Responsibilities	Percent of time dedicated to the grant				
OMPP	Director, Care Programs	Pat Casanova	Provides Clinical expertise, Policy Direction during Pre-implementation, Oversight of Quality for all Waivers,	10	5	5	5	5
OMPP	Controller	Debbie Tuggle	Oversight of and reporting of budget, including the MFP expenditures.	5	5	5	5	5
OMPP	Waiver Policy Writer	Korryn Fairman	Write and submit amendments for AD waiver to ensure inclusion of demonstration activities. Write TBI renewal.	5	-	-	-	-
DA	Division Director	Steve Smith	Manage and oversee the proposal process for the closure and conversion program and the provider capacity expansion program. Member of Quality Oversight Executive Committee.	10	10	2	2	2
DA	Division Asst Dir, Planning and Analysis	Cindy Brown	Oversight of Planning for operational plan during pre-implementation, and assist with supervision of Transition Teams . Will supervise, and oversee participant recruitment strategies.	50	50	50	50	50
DA	Project Manager	Kate Tewanger	Management and coordination of all grant activities, including leadership of the Stakeholder's groups and tracking of all qualitative and quantitative reports in order to develop ongoing systems improvement. Report grant activities to CMS.	100	100	100	100	100
DA	Program Manager	Kristy Lawrance	Assist with development of infrastructure to support those transitioned, and training initiatives for providers and caregivers, participate in work with stakeholders.	50	50	50	50	50
DA	Program Manager	Sharon Ferreira	Assist with evaluation of data through development of reports and report outcome data to Project Manager.	10	10	10	10	10
DA	State Ombudsman	Arlene Franklin	Guidance and direction over the coordination of ombudsman with Transition teams	20	20	20	20	20
DDRS	Director, Client Services	Adrienne Shields	Manage the BDDS Service Coordinators as part of the transition planning for the MR/DD NF residents.	5	5	5	5	5
Fiscal	Fiscal Analyst	Elaine Miller	Assist Project Manager with fiscal reports, analyze project spending and keep Project Manager informed with status reports.	5	5	5	5	5
Staff Offering In Kind to the MFP Demonstration Program				**2007**	**2008**	**2009**	**2010**	**2011**
OMPP		State Medicaid Director	Oversight of the NF Closure Activity. Ultimate approval of quality program development through pre-implementation; will provide clinical expertise for quality improvement initiatives.	2	2	1	1	1
OMPP		Medicaid Data Director	Oversee the data management and tracking mechanisms for data. Assist with data exchange between systems and implementation of improved and expanded information system. Provide individual level data and all required data for National Evaluation.	5	5	5	5	5
OMPP		Grants Manager	Will advise and assist project manager with grant reporting activity and assist with annual reports	2	2	2	2	2
OMPP		Waiver Policy Supervisor	Participate in work with stakeholders, oversee all policy changes that affect the transitioned individuals	5	2	2	2	2
DA		Division Asst Dir., Continuum of Care	Assist with closure and conversion activities, Director of DA waiver unit and clinical staff that reviews waiver plan of care approvals, work with quality reporting to waiver unit and ultimate responsibility for accurate reviews of CCBs	5	5	2	2	2
DA		Waiver Specialist	Provision of ad hoc reviews of clinical care plans for transitioned individuals	5	5	5	5	5

DA		Provider Recruitment Program Mgr	Recruit and provide technical assistance to providers. in order to assure that capacity issues are met for those transitioning from NF	2	2	2	2	2
DDRS		Dir. Of Community Initiatives	Tracking of outcomes of those transitioned; quality care provision and formal training of direct care providers.	5	2	2	2	2
DDRS		BDDS. Dir., Facilities and Provider	Oversight of DD service providers, oversight of Kraus initiatives which address all DD in NF settings, so will be involved in oversight of those requirements to be carried out by transition teams	2	2	2	2	2
DDRS		Waiver Unit Mgr	Oversee clinical staff involved with DD participants.	1	1	1	1	1
DDRS		Waiver Specialist	Reviews all plans of care for transitioned individuals	4	4	4	4	4
Fiscal		Director of Finance	Ultimate responsibility to advise and inform DA staff regarding status of LTC budget, and assist with MFP initiatives for allocation of LTC funding.	1	1	1	1	1
Contractors Supporting the MFP Demonstration Program				**2007**	**2008**	**2009**	**2010**	**2011**
Con-tractors		Milliman	Provide Actuarial services during pre implementation and on ongoing basis.	3	3	3	3	3
		HMA	Technical Writer to assist through Pre-implementation and evaluation narratives.	5	5	5	5	5
		HMA	Content Expert for Medicaid services, Accounting assistance throughout pre-implementation and annually	2	2	2	2	2
		HMA	Budget and Fiscal impact specialist to assist with data around expenditures for MFP admin and services	2	2	2	2	2
		Milliman	Fiscal impact and data reporting around service utilization and expenditure to crosswalk with Quality outcome data	5	5	5	5	5
		Roeing	Assist with software changes to implement case management system transfer to enhanced Enterprise system .	2	2	2	2	2
		Transition Team: 16 RNs	Assess all transitioned individuals. Oversight of Plan of need and coordination of medical care involved in Plan of Care .	25	25	40	40	40
		Transition Team: 24 Social Workers	Assist with in-depth assessment of transitioned individuals and work with AAA case managers to facilitate translation services.	25	25	40	40	40

Provide a narrative defining the costs and the methodology used to determine the costs related to each fiscal year of the project period based on the number of anticipated enrollees in the demonstration **Medicaid Administrative Costs**: Administrative costs are comprised of costs incurred for FSSA staff activities specific to the demonstration and incidental expenses, and costs incurred to provide transition team services to demonstration participants. Note that the MFP participants will constitute a "sub-group" of all persons being transitioned from NFs in Indiana as a result of Indiana's broader transition activities. Therefore, the proposed staffing plan reflects a full-time demonstration project director as well as the proportional involvement of the many staff involved in all NF transitions, but specific to their involvement with the demonstration participants. Indiana estimates that 164 demonstration participants transitioning from NFs scheduled for bed closures will receive transition team services funded from a source other than grant funds and administrative costs specific to this "group" are not, therefore, included in the State's projected administrative costs specific to the demonstration. The remaining 875 demonstration participants will receive transition team services funded through Medicaid. Transition team services encompass assessment by an RN, assistance with planning for transition and arranging supports and services by an RN and/or social worker (as appropriate) and coordination of the move from the NF. The cost for transition team services has been calculated on a per person basis assuming an average of 48 hours of transition assistance for demonstration participants (inclusive of travel time by team members) provided by an RN and social worker, with costs based on average salary and benefits for RNs and SWs, travel expenses, and equipment/supplies (including laptop computers and cell phones). The administrative costs are calculated on an annual basis assuming the transition of the number of participants.

Estimated number of individuals transitioning: Indiana expects the following sources of

eligible transitions from an institutional setting to the community: transitions arising from Nursing Facility bed closures; transitions resulting from targeting of individuals through MDS information (based on MDS data, Question Q); and non-targeted individual requests for transitions (based on historical data for transition requests). Depending on the transition source, between 50% and 85% are expected to meet the minimum timeframe for residence (6 months) that will allow eligibility for the MFP Grant. **Qualified HCB Services:** Indiana used MMIS data to identify the historic HCBS and state plan HCBS costs (e.g. HCBS waiver and state plan HCBS). Cost per enrollee for each service was estimated based on existing HCBS waiver and state plan HCBS data for each population. The historical data was adjusted to include recent reimbursement rate increases on the AD and TBI waivers, the increase in the available transition expense amount to $1,500 for demonstration participants, and the expected impact of the higher (300% SSI) income standard for HCBS waivers. The annual cost trend was reflected at 3.5% - 5.0%, based on recent trend levels for each waiver population. Using data on current HCBS waiver recipients, assumptions were developed on the number of transitioned recipients who would lapse each month (due to death, loss of eligibility, return to an institutional setting, etc.). In addition, each modeled enrollee was allowed to remain in the cost projection for a maximum of 12 months. **HCB Demonstration Services:** HCB demonstration services consist of post-transition coordination for individuals eligible for the AD Waiver and were estimated to cost $150 a month. **Total Costs:** Total costs were calculated for each service category for each month of the demonstration period by multiplying the number of eligible enrollees in each population by the corresponding cost per enrollee. Results were summed by federal fiscal year and multiplied by the appropriate FMAP rates.

Application Part 4: Assurances (5 page limit)

The transition candidate is at the center of the transition process and is the decision maker in their choice of care options. Because the single best predictor of successful transition from a NF is the individual's desire to return to a home and community-based setting, consumers will be fully informed regarding their LTC options and will be assisted as needed to facilitate their choices. Facilities that will be closing will develop an overall and preliminary discharge plan for the individual; however, the ultimate decision will reside with the individual and family as to whether they want to relocate to another facility or return to the community. Informed consent will be sought from each participating individual, as described in Part 2, Implementation Phase, Item 6. Transition teams will connect with individuals who choose to return to the community. Targeting on an ongoing basis will be prioritized based on a NF resident's indication of interest in community-based residence as identified in the MDS survey question "Q or by the individual's and/or family's request for information through ADRCs or AAAs (received directly or from other entities). The LTC Ombudsman will play a major role in this process, ensuring that Medicaid NF residents and families are informed about their LTC options and referring individuals who express interest in HCBS options to the transition team. AAAs and other entities who may receive inquiries will contact transition teams for follow-up contact, options counseling and assessment. Transition teams, comprised of a registered nurse and social worker, will also work with the LTC Ombudsman and facility discharge planner to ensure that all available LTC options are explained to the individual in the detail necessary to help them make an informed choice. Furthermore, NF residents will be provided the opportunity to visit available community residential options. FSSA will during the grant period, formalize person centered planning by developing training materials and training sessions for case managers, consumers

and HCBS providers. The DA will utilize a similar PCP model to that used by DDRS. DDRS requires their contracted statewide case management agency to utilize PCP processes as they gather information with the individual for development of the individual service plan (ISP). The DA will follow training and implementation of PCP by collection of specific measures/outcomes related to PCP to be included in consumer surveys and provider monitoring.

FSSA has made it a priority to include the public in the decision-making process, and both DA and DDRS have actively pursued this imperative. The past year has seen numerous changes to policy and programs in both divisions, and there has been successful inclusion of stakeholders, consumers, and the general public. DDRS facilitates biweekly advocacy meetings, which include trade associations, ARC leadership, and behavioral consultants. In addition, an advisory council meets monthly, and includes providers, family members, and advocates. MR/DD and Autism Commissions bring constituent concerns to the administration as well. Policy Statements are introduced through publication of a draft to these groups prior to implementation for discussion and comment. The Aging and Disabled Community is represented in numerous venues as well. FSSA DA has been meeting biweekly with a stakeholder group since February 2006. The intent of this meeting was to address capacity and access issues and the group was comprised largely of trade associations, with consumers, family members, and advocates invited to participate in those meetings. Suggestions provided in these forums have influenced rates, slot allocations, and service guidelines, among other things. For example, as this group was introduced to the MFP funding application, they requested that the individuals with TBI be considered as a target group. This was then included in the State's proposed design. A subset of this group, which included representatives from AARP, an Independent Living Center, family members, and other groups representing the aging and

disabled community, met biweekly though the summer of 2006. This group focused on policy issues around adult foster care and issues specific to TBI. Policy proposals are also brought forth from the Division's CHOICE Board and Commission on Aging. These two groups have begun to meet collaboratively to have an even stronger voice in elderly affairs.

Another prime example of FSSA's dedication to public input has been through this year's dedicated efforts to implement consumer direction in the AD Waiver. Before the design for consumer directed attendant care was fully developed, there were three focus groups held around the state to gather input from consumers, providers, and care managers. The input was valuable and often resulted in programmatic changes. For example, how to handle consumer fraud was an issue that was improved as a result of these stakeholder discussions, as was the format and accessibility of the training manuals. The finalized manuals for CDC are much improved as a result of this shared process, resulting in a stronger program. The CPASS Task Force, comprised of consumers, family members, AAA leadership, and others faithfully met for many months to identify service definition issues and to review the training manuals. Outreach to interested consumers has resulted in over 200 consumers and providers, and most AD Waiver case managers receiving formal training in the past 9-10 months.

Listening sessions have been a strong tool in gleaning input from communities and consumers. The FSSA DA held three listening sessions during early 2006 as major policy decisions were being considered. Also, the FSSA minority outreach staff, DA program managers, and the DA Director have visited approximately 40 nursing facilities, adult day service programs, assisted living centers, a TBI rehab center, and adult foster care homes over the past 10 months, in all areas of the State. Visits generally include a tour of the facility, but the most useful part of these visits is the state staff interaction with the program participants. The

staff has had the opportunity to learn from the consumer what services are important to the individual—what they like about where they are served and what they dislike. The Director, in particular, has visited a large number of NFs and the FSSA transition program has benefited from this by gaining insights about what circumstances have caused individuals to choose, or be placed, in NFs, and what barriers are currently keeping them there. As a result, housing and transportation services are now a higher priority in the FSSA planning process. Through ongoing collaborations with State Housing and Transportation divisions, plans are well underway to address these voiced needs through additional funding and staff time.

There will again be regional listening sessions around the State to obtain direct input into what communities feel are essential HCBS for those individuals returning to the community from NFs specific to the MFP demonstration. Focus groups with LTC Ombudsman, case managers, discharge planners, and the individuals residing in NFs and/or their family members will be sought in forums accessible to the participants.

A NF Transition Stakeholder Workgroup has been formed and invitees include individual consumers and family members along with representation from the following organizations: NF Assoc., IN ADS Assoc., IN AL Assoc., IN Home Health and Hospice, IN Protection and Advocacy, CHOICE Board, Commission on Aging, INARF, ARC, Univ. of Indianapolis Center for Aging and Community (housing focus), mental health professionals, IN Brain Injury Assoc., Alzheimer's Disease Task Force, Independent Living Centers, IN211, LTC Ombudsman, AAA case management, Housing Authority, the Community and Consumer Advisory Council and others. The first meeting of this group was held October 16, 2006 to describe the MFP demonstration and proposed design, respond to questions and gather suggestions for design features. This group will meet throughout the grant period providing input on all critical program

elements including the operational protocol development, transition process and materials, resource development, tracking and data analysis, and outcomes evaluations.

The State assures that it will to continue to work toward a more appropriately balanced system of services provided in home and community-based settings and institutional settings. This effort is already underway through the use of the Quality Assessment Fee closure fund, the provision of additional funding to serve those on the AD Medicaid Waiver waitlist (add something here about activities related to DD) and the focused efforts to build more capacity for serving vulnerable citizens in the community. As illustrated in Attachment 4, the State plans to continue to dedicate more funding to serving persons with disabilities and the elderly in home and community-based settings.

The State assures that reports specified by CMS designed to permit reliable comparisons of MFP projects across the country will be submitted in accordance with specifications from CMS regarding content, format, timeliness and other requirements.